Reform of the clinical excellence awards scheme: why are we waiting?

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In July 2011 the Review Body on Doctors' and Dentists' Remuneration submitted to the department of health its review of compensation levels, incentives and the clinical excellence and distinction award schemes for NHS consultants. Ministers are still considering its recommendations, and the report remains unpublished. In anticipation of its eventual publication, we would like to rekindle debate on appropriate compensation and incentives for NHS consultants.

Compensation, recruitment and retention

Consultant services were described by the official NHS historian as 'the pivot upon which the National Health Service turned … the elite corps, whose willing participation was regarded by Bevan as fundamental to the image of the NHS as a first class service … ushered into the state hospital service on privileged terms.'[1] Hospital consultants remain a pivot upon which the performance of NHS hospitals turns, and it remains crucial to recruit, retain, reward and motivate them appropriately.

In general, salary levels are used to attract and retain staff, whereas performance related pay and bonuses are used to stimulate performance. Consultants' basic pay remains generous relative to comparable public sector professions. This ensures recruitment and retention, as well as rewarding the clinical and managerial skills of consultants and the highly responsible nature of their job. There is little evidence of difficulties in recruitment and retention of NHS doctors, although there are reported difficulties in particular specialties (including accident and emergency, anaesthetics, obstetrics and gynaecology, paediatrics and psychiatry).[2]

Using incentives to encourage and reward

Behaviour is a product of incentives, which come in many forms. Financial incentives can be explicit or implicit, and important non-financial incentives include trust, duty and reputation.

Confucius argued that 'without trust we cannot stand'.[3] Economist Adam Smith argued that the primary driver of people was not self interest and greed but a sense of duty.[4] Another important determinant of behaviour is reputation, for example the desire not to be shown to be a poor outlier in a distribution of activity and outcomes, as illustrated by publishing comparative outcomes in cardio-thoracic surgery, which improved average performance and reduced dispersion.[5] As argued elsewhere, we believe the scope for using reputational incentives is considerable,[6] and the department of health in their evidence to the review body stated that 'greater use should be made of systems of non-financial recognition', with suggested examples including 'surgeon of the year' and 'consultant with the most improved productivity'.[7] This does not, though, preclude reform of existing financial incentives.

In salary-based systems like NHS hospital pay, doctors are paid to provide a certain minimum amount of their time to perform a broadly defined role, rather than a set of detailed tasks.[8] Salaries contain no explicit incentives to increase activity, whereas fees for service may contain too many. If salary is used without any supplementary explicit incentives (such as bonuses or performance related pay), regulation or implicit incentive structures may be required to increase

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activity rates, whereas fees for service may require regulation to avoid over-treatment and cost inflation.

The relationship between doctor and patient is often used as an example of an agency relationship, where the doctor's specialized knowledge of the relationship between healthcare and health status is made available to the patient, to aid their decision making.[9] But doctors clearly have interests of their own – 'income, leisure, professional satisfaction, which are partially congruent and partly in conflict with that of the patient'.[10] In response, professionalism and self-regulation have emerged,[10] with codes of medical ethics and conduct.

Alongside this imperfect agency relationship, doctors, as their actions often determine the actions of teams of staff and control substantial budgets, must act as agents of their employers or funders – in the English NHS – of hospitals, commissioners and broadly of taxpayers. Doctors have been described as 'double agents', needing to serve both the interests of their patient and employers.[11] It is essential that, in acting on behalf of the patient in front of them, doctors do not neglect other patients and potential patients by ignoring the opportunity costs of treatment and other decisions.[12]

Economic theories of agency relationships stress the necessity of designing an 'incentive compatible contract' with some form of performance related pay.[13] This is a complex task, as it is difficult to pay doctors on the basis of 'success', which is problematic to measure and to attribute. Nevertheless, like other employees, doctors may be paid bonuses for achieving explicit targets, or for a less defined goal of 'merit' or 'excellence', as in the clinical excellence award scheme.

In considering financial incentive schemes, it is important to emphasize that individuals, even those interested primarily in financial gain, are not interested only in their current rewards, but are motivated to increase effort by the likelihood of future rewards over a lifetime. 'There is more to incentives than simply more jam today. Many individuals who do not receive any performance related bonus are nevertheless strongly motivated by the possibility of either promotion within the organization or a better job offer from an outside firm.'[14] These motivations, known as 'career concerns',[15,16,17] link current performance to future wages,[14,15] particularly in the public sector.[16,17]

Reforming the clinical excellence awards scheme – can we use incentives better?

In designing the GP contract, with the quality and outcomes framework, UK policy-makers embraced the use of direct explicit financial incentives – it is a clear example of performance related pay,[18] although it is impossible to separate the effect of payment from the reputational effect of publishing practice scores. Current NHS hospital payment systems are based on salary, which contains no explicit incentives for individual productivity. The new consultant contract did make some use of explicit financial incentives, in particular by a contractual obligation for consultants to provide up to two extra programmed activities (PAs) to the NHS before they are allowed to undertake private practice. In principle this increased the consultant time available to NHS managers, but in practice it may have simply provided extra reward for work that many consultants were already doing.

Clinical excellence awards are the main explicit financial incentive scheme for consultants. Although these payments are intended to reward 'excellence', and contributions made beyond that expected from consultants doing their job, local level clinical excellence awards committees were until 2011 encouraged or even obliged to award at least 0.35 of an award per eligible consultant they employ.[19] In the 2011 round, the ratio of new employer-based awards to eligible consultants was changed to 'at least 0.20' to reflect current financial constraints in the NHS.[19] The scheme is costly – a crude multiplication of existing award holders[20] by the cost of the award they hold (including the award, pension and national insurance costs)[21] suggests that the scheme in 2011 cost over £500 million, and this may be an underestimate. Award levels in 2011, with numbers of award holders and estimated costs per award are illustrated in Table 1.

Clinical excellence and distinction awards are based on 'merit', where staff are evaluated infrequently on ill-defined measures of performance, rather than explicit monitored performance

Table 1
Number of award holders and estimated costs of clinical excellence awards, 2011

Level of award	*Number of award holders**	*Amount of award (£)*	*NHS Pension costs (£)***	*National insurance costs (£)***	*Annual gross costs (£)***
Employer-based awards					
1	4,017	2,957	414	408	3,779
2	3,436	5,914	828	816	7,558
3	2,661	8,871	1,242	1,224	11,337
4	2,158	11,828	1,656	1,632	15,116
5	1,724	14,785	2,070	2,040	18,895
6	1,363	17,742	2,484	2,448	22,674
7	1,083	23,656	3,312	3,265	30,232
8	884	29,570	4,140	4,081	37,790
9	1,473	35,484	4,968	4,897	45,349
National awards					
Bronze	1,762	35,484	4,698	4,897	45,349
B***	419	31,959	4,231	4,411	40,601
Silver	769	46,644	6,530	6,437	59,611
Gold	261	58,305	8,163	8,046	74,514
A***	201	55,924	7,830	7,717	71,471
Platinum	168	75,796	10,611	10,460	96,867
A plus***	74	75,889	10,624	10,473	96,986

*Award holders in England and Wales, (Source: ACCEA 2011[20])
**Estimated gross cost of clinical excellence awards from Imperial College Finance Division[21]
***Distinction Awards (B, A and A plus) are assumed to have the same proportional pension and national insurance costs as national level clinical excellence awards (Bronze, Silver, Gold and Platinum).

targets. In practice this often has an aura of 'turn-taking' and it lacks any direct link to an objective measure of the productivity of individual consultants in terms of outputs or outcomes, or to other measures of performance. Increasing productivity, in terms of treating NHS patients, may be a weak signal of work effort to those allocating clinical excellence awards, as employers (chief executives of NHS Trusts) typically do not monitor the productivity of hospital consultants, and such measures are not generally used to allocate awards. Despite this, it appears that local clinical excellence awards appear to be associated with slightly higher clinical activity, although national awards are not.[22,23]

Research into the effectiveness of merit pay is limited, but for it to improve motivation to increase performance and productivity, good signals of consultant performance to those allocating clinical excellence awards would have to be clear. Unlike NHS activity and quality, other work undertaken by consultants may be a more obvious signal to employers and medical peers, particularly for the higher level awards. Examples may include teaching and training, research and publications, activities for royal colleges and other regulatory bodies and innovation. Psychologists have developed theories of 'strategic pay' which, although under-tested, indicate the potential importance of taking strategic objectives of the organization into account in payment systems. As policy-makers are increasingly concerned with productivity in the NHS, it would be useful to include productivity objectives, directly or indirectly, into individual reward systems, and this could be implemented as part of the clinical excellence awards scheme. Data collection on patient level costs (which could be aggregated by consultant), clinical activity (e.g. episodes per year, adjusted for casemix differences) and outcome (e.g. patient reported outcome measures) are all improving over time, and if incorporated and reported to awards committees they could potentially inform and improve decisions about allocation of clinical excellence awards.

While policy makers have at many levels embraced the use of explicit incentives to stimulate productivity in the medical labour market, the use of implicit incentives, or 'career concerns', remains neglected. These theories incorporate a longer-term view of incentive structures, recognizing that individuals are motivated not just by short-term financial gain but by long-term income, including promotion. In practice, hospital consultants have no promotion structure: once fully trained consultants, doctors are essentially at the top of their careers. Without taking on additional responsibilities (such as management or administration) they are faced solely by a poor system of merit pay, with few promotion opportunities related to evidenced clinical performance and 'productivity' in terms of direct patient care. There are essentially no implicit incentives beyond the level of consultant, which is achieved relatively early in the careers of most hospital doctors, on average before the age of 35.[24] This flat career structure is unusual in professionals, particularly those working in the public sector. It is surprising that medical careers make no real use of implicit incentives, and appear not to have done since the inception of the NHS. Implicit incentives could stimulate medical performance while avoiding some of the unintended consequences of explicit bonus payments.

We believe there is a case for replacing clinical excellence awards with a system of earned increments and a senior consultant grade, which could be introduced in a cost neutral manner. A senior consultant grade, providing recognition for a sustained and measured contribution to NHS care, would be a more appropriate and more respectful reward for the best of this key staff group than current clumsy attempts to use performance related pay.

Conclusions

Distinction awards have been contentious since their introduction. As a method of remuneration, they were regarded as an anomaly within the public services,[1] and although supported by the Department of Health, they were viewed by the Treasury in 1958 as 'a blot on the landscape of public finance'.[1] From early on, there have been variations and perceived inequities in their distribution, both geographically and by specialty. These and other variations (e.g. related to gender and ethnic group) have declined over time, particularly since publication of award holders, but perceived inequities remain. If the outdated merit-based scheme is to be retained, it should be developed to encourage directly NHS priorities, including better signals of NHS clinical activity, outcomes and costs, rather than the vaguely defined 'excellence' which too often rewards non-clinical activities.

We favour, however, removing the scheme altogether, and replacing it with a simpler, clearer reward structure using earned increments and a senior consultant grade. In this system, NHS hospital doctors could gain extra status and income through a clear promotion procedure focused on clinical performance. This is more consistent with principles of fairness and with the structure of other public sector reward schemes, and more responsive to the local priorities of NHS employers. It also has potential, instead of rewarding external activities related to esteem, to encourage and reward good clinical care and improved NHS performance and productivity.

The clinical excellence award scheme is an anachronistic system in need of reform. Why are we waiting?

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